NEW PATIENT APPLICATION

Welcome to Cohen Chiropractic Centre! Please answer all questions to the best of your ability. Thank you.

Name:____Today's Date:________________

Address:____

City/State/Zip:____________________________________ E-Mail:________________________________

Phone: Cell:__________________ (H):________________ (W):________________ Fax:________________

Birth date:______/______/______ Age:__________ Social Security #:_____________________

Marital status: ☐ Married ☐ Partnership ☐ Widowed ☐ Divorced ☐ Single

Number of Children: ______Children's names & ages:_______________________________________

Employer Name: __________________________________ Occupation:____________________________

Employer Address:____

Spouse/Partner Name:____ Age:_______________

Spouse/Partner Employer:____

Who may we thank for referring you? ____

Favorite hobbies or interests:____

Last time you went to a Doctor of Chiropractic:____

Name of your prior Doctor of Chiropractic:_______________________________City/State:_________________

Chiropractic techniques you've had success with:____

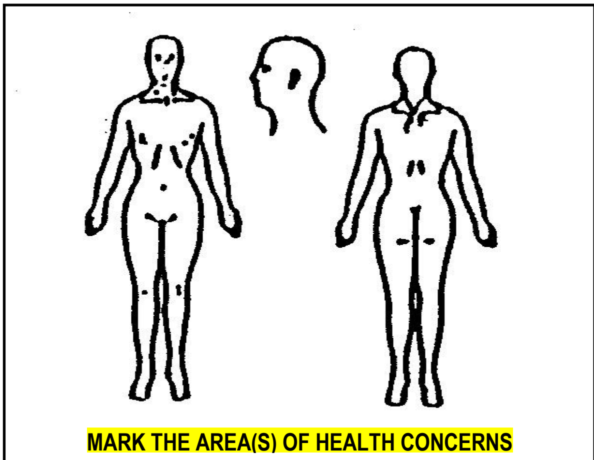
Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card ☐ FSA/HSA

Do you have health insurance? ☐ Yes ☐ No

Primary Insured: ☐ Self ☐ Spouse/Partner

General Practitioner Name:_________________________________

Phone:____



MARK THE AREA(S) OF HEALTH CONCERNS

Cohen Chiropractic Centre
2140 Peachtree Rd, Suite 203
Atlanta, GA 30309
404-355-5499
www.CohenChiropracticCentre.com

Health reasons for consulting our office, ***with number one being of greatest importance***:

1.______________________________ 3.______________________________

2.______________________________ 4.______________________________

Please list any specialists you are currently receiving care from:

Name: ______________________________ Phone: ______________

Name: ______________________________ Phone: ______________

Have you had same or similar problem(s) before? ☐ Yes ☐ No

How long?__________ Please explain:______________________________

Do any of the following immediate family members have the same condition?

☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Children

Has anyone in your family ever suffered from the following:

☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ HIV/AIDS
☐ Menopause/Hormone Pathology ☐ Infertility ☐ Migraines ☐ Thyroid
☐ Degenerative Disk/Osteoarthritis ☐ Scoliosis ☐ Depression/Mood Disorder/Anxiety

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what type?______________

If Yes, are you presently undergoing treatment? ☐ Yes ☐ No If so, what type?______________

Do you still have your: Appendix ☐ Yes ☐ No Gall Bladder ☐ Yes ☐ No
Tonsils ☐ Yes ☐ No Reproductive Organs ☐ Yes ☐ No

Please list any surgeries you have had: ______________________________

Is the reason for your visit the result of an auto or work injury? ☐ Yes ☐ No If yes, when?__________

Other doctors who have treated this problem:______________________________

Medication(s) you currently take:______________________________

What have you heard about chiropractic care?______________________________

Do you know what a subluxation is? ☐ Yes ☐ No If yes, please describe______________________

What daily rituals for spinal health do you presently practice?______________________________

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.
Patient or Guardian Signature:______________________________ Date:__________

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